**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-05-2840.M5**

MDR Tracking Number: M5-04-2869-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution-General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 5-4-04.

The IRO reviewed office visits, electrical stimulation (unattended), electrical stimulation, ultrasound, massage, therapeutic exercises, shock wave therapy, and iontophoresis.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the medical necessity issues. The IRO concluded that the office visits, electrical stimulation (unattended), electrical stimulation, ultrasound, massage, therapeutic exercises, shock wave therapy, and iontophoresis were medically necessary from 9-2-03 to 10-28-03. The IRO agreed with the previous determination that the office visits, electrical stimulation (unattended), electrical stimulation, ultrasound, massage, and therapeutic exercises were not medically necessary from 10-31-03 to 11-11-03. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purpose of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 7-15-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Codes 97014, 97035, 97124, 97110 billed for date of service 9-19-03 were denied as "K – reimbursed denied based on the provider's absence from TWCC's approved doctor list, licensing board restrictions, or provision of unsupervised treatment outside of scope of practice."

The requestor did not provide documentation to support their ADL status. Therefore, no review made and no reimbursement recommended.

Codes 99212 billed for date of service 10-14-03 and 99213 billed for dates of service 10-15-03 and 10-17-03 were denied by the carrier as "Y, MU – physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day."

The Trailblazer Local Coverage Determination (LCD) states in part, "When both a modality/procedure and an evaluation service are billed, the evaluation may be reimbursed if the medical necessity for the evaluation is clearly documented. Standard medical practice may be one or two visits in addition to physical therapy treatments. Reimbursement beyond this standard utilization requires documentation supporting the medical necessity for the office visit."

The LCD does not prohibit the billing of office visits with evaluation and management codes and the office visits on these dates of service were not denied for medical necessity. Therefore, recommend reimbursement as follows:

- Code 99212 , Per Rule 134.202(b) and the Medicare Fee Schedule , the MAR is $37.13 x 125% = $46.41.

- Code 99213, Per Rule 134.202(b) and the Medicare Fee Schedule , the MAR is $52.17 x 125% = 65.21 x 2 days = $130.42.

The above Findings and Decision is hereby issued this 26th day of October 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service after August 1, 2003 per Commission Rule 134.202 (c);

- Plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 9-2-03 through 10-28-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 26th day of October 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION **AMENDED LETTER 10/13/04**

July 8, 2004

Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-2869-01
IRO Certificate #: IRO4236

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in Chiropractic

Medicine. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 30-year-old male sustained an injury while at work ___. The patient was working with a metal bar to pry a piece of wood from concrete when the bar slipped and struck the left side of his cervical spine, left ribs, and left shoulder region. An MRI of his c-spine showed a small disc bulge the MRI of the left shoulder was negative/essentially normal. Plain films ordered by the company doctor revealed a fractured left ribs and the patient was placed on light duty. He has been treated with physical therapy (massage and therapeutic exercises), Celebrex, Skelaxin, EMG (normal) of upper extremities, and a functional capacity evaluation.

Requested Service(s)

99212, 99213-OV, 97014/G0283-Electrical Stimulation unattended, 97032-Electrical Stimulation, 97035-Ultrasound, 97124-Massage, 97110-Therapeutic Exercises, G0280-Shock Wave Therapy, 97033-Iontophoresis from 09/02/03 through 11/11/03

Decision

It is determined that all treatment from 09/02/03 through 10/28/03 is approved. All treatment after 10/28/03 is denied.

Rationale/Basis for Decision

Physical medicine is an accepted part of a rehabilitation program following an injury. The patient’s history, the mechanism of injury and the diagnostic imaging studies fully supported the medical necessity of twenty-four physical treatments for a time period not to exceed 8-weeks.

Sincerely,